The Prisoner Ombudsman for Northern Ireland

OFFICIAL - SENSITIVE

INDEPENDENT INVESTIGATION REPORT INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

Mr DENISAS TURKINAS
AGED 36
AT MAGHABERRY PRISON
ON 6 JUNE 2021

Date finalised: **10 December 2025**

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Foreword from the Prisoner Ombudsman

Denisas Turkinas, a 36 year old Lithuanian national died in Maghaberry Prison on 6 June 2021.

This report aims to outline the treatment and care Mr Turkinas received while in custody prior to his death and the circumstances leading up to it. The responsibility for the care and wellbeing of prisoners lies with the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust.

Both organisations have cooperated fully in this investigation and have had the opportunity to review the report for factual accuracy.

It is crucial any opportunities for learning are addressed and good practice is acknowledged and shared across the custodial environment. It is only through this process that prisoners and their families will have confidence in the prison system, the standard of medical care, the investigation itself and the operational independence of the Office of the Prisoner Ombudsman.

I am conscious of the length of time Mr Turkinas' family has had to wait for the completion of this investigative report and appreciate their patience.

The report provides as much detail as possible about Mr Turkinas' time in custody and the circumstances surrounding his death. I hope this information will be helpful to his family as they piece together the last days of his life.

Mr Turkinas was remanded into the custody of Maghaberry Prison in the afternoon of 5 June 2021 and had had one previous period in custody in 2020.

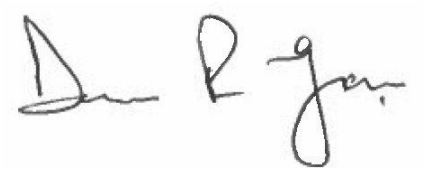
Mr Turkinas was a new committal detained during the Covid 19 pandemic. At this time the process for new committals was to complete a period of 14 days in quarantine in Foyle House Maghaberry Prison prior to being admitted into the wider prison establishment. However, due to Mr Turkinas' behaviour when he first arrived at Maghaberry Prison, the decision was made to initially house him in the Care and

Supervision Unit. He was escorted there by the Dedicated Search Team. On 6 June 2021 Mr Turkinas was transferred to Foyle House where at 16:04 he was found unresponsive in his cell. Despite attempts, Mr Turkinas could not be resuscitated, and his life was recognised as extinct at 17:02.

To assist consideration of the healthcare aspects of Mr Turkinas' time in custody, and the potential impacts on his wellbeing, a Clinical Reviewer was commissioned. The Clinical Reviewer's report included areas of good practice about Mr Turkinas' assessments and the emergency response when he was found. These are included in this report.

I would like to thank all those who contributed to the preparation of this report including the Northern Ireland Prison Service and South Eastern Trust's Healthcare in Prison team.

I offer my condolences to Mr Turkinas' family on their loss.



Darrin Jones
Prisoner Ombudsman for Northern Ireland

The Role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland is responsible for providing an independent and impartial investigation into deaths in prison custody in Northern Ireland. This includes the deaths of people shortly after their release from prison and incidents of serious self-harm.

The Prisoner Ombudsman (Ombudsman) is an independent appointment made by the Minister of Justice and his Investigating Officers are completely independent.

The purpose of the Ombudsman's investigation is to find out, as far as possible, what happened and why; establish whether there are any lessons to be learned; assist the Coroner's investigative obligations under Article 2 of the European Convention on Human Rights (ECHR) and make recommendations to Northern Ireland Prison Service (NIPS) and the South Eastern Health and Social Care Trust (the Trust) for improvement where appropriate.

The Trust was established on 1st April 2007 and is one of 5 Trusts in total within Northern Ireland. The South Eastern Trust has responsibility for providing healthcare to all prisoners in Northern Ireland. This is delivered on a day to day basis by the Healthcare in Prison (HiP) team. While they are based in the establishments, they are not part of NIPS.

By highlighting learning to NIPS, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

The Terms of Reference and general investigation objectives for our investigations are available at www.niprisonerombudsman.com/index.php/publications.

The general investigation objectives are tailored to each independent investigation and the objectives for this investigation are to:

- establish the circumstances and events surrounding the death of Mr Turkinas, including the care provided by NIPS;

- examine any relevant healthcare issues and assess the clinical care provided by the Trust;
- examine whether any changes in NIPS or Trust operational methods, policy, practice or management arrangements could help prevent a similar death in the future;
- ensure Mr Turkinas' family has an opportunity to raise any concern they may have, and take these into account in the investigation;
- identify commendable practice;
- make recommendations for improvement where applicable; and
- assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights.

In the interests of openness and transparency, investigation reports are published on the Ombudsman's website. Reports are also disseminated to those who independently monitor services in prisons and the care and treatment of prisoners. These include the:

- Criminal Justice Inspection Northern Ireland (CJI);
- Regulation and Quality Improvement Authority (RQIA); and
- Independent Monitoring Boards (IMBs).

More information about published reports from these organisations can be found at Appendix 2.

SECTION 1: Investigation Objectives

Mr Turkinas was committed to Maghaberry Prison in the afternoon of 5 June 2021. He was escorted to the Prison directly from Police custody by the Police Service of Northern Ireland (PSNI). Due to his behaviour at committal, which was noted to be "volatile", he was transferred directly to the Care and Supervision Unit (CSU) by the Dedicated Search Team (DST) [1] where he spent his first night in custody. On the morning of 6 June 2021, Mr Turkinas was transferred from CSU to Foyle House. At 16:04 on 6 June 2021 Mr Turkinas was found suspended by a ligature in his cell. Despite the efforts of NIPS and HiP staff Mr Turkinas passed away.

The objectives of this investigation, which take into account questions raised by Mr Turkinas' family, are to:

1.	establish the circumstances and events surrounding Mr Turkinas' death on 6 June 2021 including an overview and examination of his committal and the immediate responses when he was found;
2.	examine whether the provision of healthcare services provided by the Trust to Mr Turkinas were at least equivalent to those he might have received in the community
3.	identify any relevant failing or commendable practice, and highlight any lessons learned from the death of Mr Turkinas; and
4.	assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights by ensuring as far as possible the full facts are

[1] The DST are responsible for carrying out prisoner, prison and staff searches to ensure there is no contraband being trafficked within the prison and maintaining order and discipline within a safe and secure environment. They are specially trained individuals tasked with escorting prisoners through the establishment when there is a possibility of disruptive behaviour.

brought to light and any relevant failing is exposed, any commendable practice is identified and any lessons from the death are learned.

SECTION 2: Methodology

The investigation methodology aims to thoroughly explore and analyse all aspects of each case. This report is structured to detail the events and emergency response leading up to and given to Mr Turkinas on 6 June 2021. It comprises interviews with NIPS staff, HiP staff, prisoners, family and friends. All prison records in relation to the deceased's life while in custody are examined, including CCTV footage, telephone calls and mail.

Notices of investigation into Mr Turkinas' death were issued to relevant parties within Maghaberry Prison, including prisoners, NIPS staff and the Independent Monitoring Board (IMB). This enables anyone with information to come forward and speak to the Ombudsman's investigators.

2.1 Independent advice

Once the medical evidence was obtained and reviewed, advice was sought from an independent professional Clinical Reviewer. The Clinical Reviewer is a registered Adult Nurse with extensive experience in Primary Care, Secondary Care and Health in Justice across both the National Health Service (NHS) and private sector.

The Clinical Reviewer contributes their expertise in the development and implementation of primary care, mental health and substance use programs at local, regional and national levels. The Clinical Reviewer also holds responsibility for national clinical leadership in resuscitation management and safeguarding.

The information and advice which informed the findings and conclusions are included within the body of this report. The Clinical Reviewer provides advice only and, based on the overall context of the case, this advice may be included within the recommendations for this report.

2.2 Family Liaison

Liaison with the deceased's family is a very important aspect of the Ombudsman's role when investigating a death in custody. On 15 October 2021 Mr Turkinas' family met with the then Prisoner Ombudsman and asked that the following areas be included in the Ombudsman's investigation:

1. Why was Mr Turkinas not deemed at risk of suicide?
2. Why did Mr Turkinas not receive medication for withdrawal?

SECTION 3: Summary of Mr Turkinas Case

On 4 June 2021 the PSNI arrested Mr Turkinas. During his arrest Mr Turkinas became aggressive and attempted to flee from police and he made threats to self-harm. Mr Turkinas was taken into custody and appeared at the Magistrates court on 5 June 2021. He was remanded to Maghaberry Prison with bail fixed pending an approved address.

From the Safer Custody Report[2], on arrival at Maghaberry Prison, Mr Turkinas was deemed to be "volatile" and a decision was made to interview him in the PSNI vehicle. He was taken under control and restraint[3] directly to CSU. Mr Turkinas was deemed as *"No Apparent Risk"* following this initial assessment.

Mr Turkinas was seen by Nurse C for his *Committal Healthcare Assessment* in the CSU. He denied any thoughts of self-harm or suicide, both past and present. While his spoken English was noted as being "good" it was also recorded that he would benefit from the use of an interpreter which would help Mr Turkinas' understanding. From electronic care records, an entry created by Nurse C, it was also noted that Mr Turkinas would need opiate withdrawal support.

On 6 June 2021 Mr Turkinas was seen by Governor A who approved a move from the CSU to Foyle House. Mr Turkinas was moved at 11:06. From the records obtained, during the course of the day Mr Turkinas had frequent interactions with NIPS staff on the Landing. At 14:45 Mr Turkinas was unlocked to attend a mental health triage by Mental Health Team (MHT) Mental Health Practitioner A. It was noted Mr Turkinas was pleasant and jovial; however, the assessment was rescheduled for the following day to allow an interpreter to be in attendance.

[2] A Safer Custody Report is a document used by NIPS to provide an overview of a prisoner. It includes a summary of the prisoners initial interview and presentation when committed to Prison

[3] Where the planned use of force is necessary, only certified staff should be used to apply Control and Restraint techniques unless this would be impractical in the circumstances prevailing. Control and Restraint techniques are designed to allow staff and others, where the Use of Force is necessary, and there is no other viable alternative, to deal safely and effectively with non-compliant, disruptive, potential or actually violent situations, using the level of force appropriate to the situation, with the minimum risk of injury to staff, subjects or others. Control and Restraint techniques must not be employed unnecessarily, or in a manner which entails the use of more force than is necessary. The use of control and restraint techniques will always be based on an assessment or response to subject actions, or a balanced perception of the perceived threat.

At 15:40 Mr Turkinas' cell was unlocked by Prison Officer C to allow NIPS staff to light a cigarette for him. At 16:00 NIPS staff started to distribute the evening meal on Landing 1 of Foyle House. At 16:04 when Prison Officer A and Prison Officer B reached Mr Turkinas' cell they found him hanging from a ligature. A *'code blue'* alarm[4] was raised by Prison Officer C. An ambulance was tasked to Maghaberry Prison.

Prison Officer A and Prison Officer B entered Mr Turkinas' cell in order to take the weight of Mr Turkinas. Prison Officer C used a Hoffman knife to remove the ligature. To facilitate medical attention Mr Turkinas was taken out of the cell and onto the landing. Prison Officer B immediately commenced cardiopulmonary resuscitation (CPR). NIPS staff were joined by HiP Nurse C and Nurse E.

An ambulance from the Northern Ireland Ambulance Service (NIAS) arrived at Maghaberry Prison at 16:36 and a second ambulance arrived at 16:53. At 17:02 NIAS Paramedic A and NIAS Paramedic B pronounced no recognition of life.

The cause of Mr Turkinas' death stated in the Post Mortem report was hanging.

[4] The term "code blue" is an emergency code used to describe the critical status of an individual. Prison Officers may call a code blue if a prisoner goes into cardiac arrest or has respiratory issues.

SECTION 4 – Background Information

4.1 Maghaberry Prison

Maghaberry Prison is a high security prison that holds adult male sentenced and remand prisoners.

Since 2008 the Trust has seen a diversification of professions and the range of services provided. HiP is planned and delivered in line with primary care services in the community.

Within Maghaberry Prison there is access to 24-hour primary healthcare emergency response; and the MHT are on site Monday to Friday between 08:00 and 17:00. At this time HiP were piloting a 7 day mental health service, leading to the opportunity for Mr Turkinas to be assessed over the weekend.

Maghaberry has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable prisoners.

NIPS and the Trust jointly commissioned an external review of the Supporting People At Risk Evolution (SPAR Evo)[5] procedure, which was published on 23 May 2024. The external review of the SPAR Evo procedure contains a number of recommendations that aim to enable better information sharing between NIPS and the Trust as well as support for those prisoners who are assessed. The Ombudsman's Office will be updated on the out workings of these recommendations.

[5] SPAR Evo Supporting People At risk Evolution (SPAR Evo) was jointly developed by NIPS/SEHSCT in 2018 and was signed off by both organisations in April 2019. The approach is person centred and aims to support people through a period of crisis or distress in a way that meets their needs

SECTION 5: Chronology of Events Leading up to Mr Turkinas' Death

5.1 Events from 21 October 2020 to 11 November 2020

Prior to June 2021 Mr Turkinas had one previous period in custody. He was remanded from 21 October 2020 to 11 November 2020 in Maghaberry Prison. Due to the pandemic he was quarantined in Foyle House which had been reopened in response to the pandemic. At his committal Mr Turkinas reported no history of self-harm or suicide but did report that he was experiencing opiate withdrawal. During this period in custody attempts had been made to contact translation services in order to assist Mr Turkinas at committal; however, these were unsuccessful. No reason was identified.

On 21 October 2020 Mr Turkinas requested to see Nurse A for abdominal pain. Prior to Nurse A arriving at Landing 2 of Foyle House Mr Turkinas started a fire in his cell. As NIPS staff escorted Mr Turkinas from his cell he grabbed a piece of broken glass from the 'smoke hood break glass' and put it in his mouth. Mr Turkinas was instructed to remove it which he eventually did. NIPS staff held Mr Turkinas using control and restraint measures. He was relocated to CSU and a SPAR Evo care plan was opened. From electronic care records Mr Turkinas was seen by Nurse A and Paramedic A. It was noted he had no burns but did have minor lacerations to his wrists, his tongue and his throat.

Mr Turkinas declined an abdominal examination and reported to Nurse A that he wanted sleeping tablets to help with his withdrawal symptoms. Nurse A entered this incident on the electronic care record system. They also recorded an out of hours doctor was contacted and Mr Turkinas was prescribed Zopiclone[6].

[6] Zopiclone is used to treat sleeping problems (insomnia).

Mr Turkinas remained in the CSU where he was monitored and assessed for drug withdrawal through a collaborative approach between NIPS and HiP under a SPAR Evo care plan. During this time Mr Turkinas became aggressive when waiting for medication or tobacco and made further threats to start fires if he did not receive same. Mr Turkinas was released on 11 November 2020.

5.2 Events from 5 June 2021 and 6 June 2021

Maghaberry Prison 5 June 2021

On 5 June 2021 Mr Turkinas was remanded to Prison by a Magistrates court and transported to Maghaberry Prison following a period in PSNI custody. He was described as "volatile" causing damage to the PSNI vehicle. Due to his behaviour the decision was made to proceed with his committal interview in the PSNI vehicle. NIPS officers determined Mr Turkinas understood enough English to conduct the interview, and he was informed of the committal process and quarantine requirements.

Details from the Prisoner Escort Record noted Mr Turkinas had depression and an opiate addiction. He had been violent in the past with staff in the Police custody suite and had placed a scalpel at his own throat and threatened to self-harm.

NIPS evidenced Mr Turkinas was spoken to regarding the details of his *Police And Criminal Evidence* (PACE)[7] notes and was asked about his history of self-harm and suicide. These details were added to Mr Turkinas' safer custody profile. Mr Turkinas confirmed this was historical and he had no current thoughts of either self-harm or suicide. He was made aware of support services available and how he could access same. He was also advised he could raise any medical concerns with the nurse during his healthcare committal assessment.

[7] The Police and Criminal Evidence Act 1984 (PACE) is an Act of Parliament which instituted a legislative framework for the powers of Police Officers to combat crime. The purpose of the Act was to unify police powers under one code of practice and to carefully balance the rights of the individual against the powers of the Police. The Act provides codes of practice for the exercise of police powers. Equivalent provision is made in Northern Ireland by the Police and Criminal Evidence (Northern Ireland) Order 1989.

At 13:40 the NIPS DST were tasked with moving Mr Turkinas from the PSNI vehicle and at 13:55 he was escorted to the CSU.

At 14:05, in line with NIPS procedures following a prisoner being involved in a close escort, HiP Nurse B completed an examination of Mr Turkinas. Nurse B recorded there were no injuries sustained as a result of the DST escort but that Mr Turkinas had a swollen right wrist and bruising to both wrists which was attributed to being placed in police handcuffs.

HiP Nurse C completed Mr Turkinas' initial committal nursing assessment at 14:22. This interaction was placed on the electronic care records at 16:47. Nurse C recorded while Mr Turkinas was able to converse in English it was difficult to assess his level of understanding, and he would benefit from the services of an Interpreter. Initially this was not possible due to his aggressive behaviour. Nurse C recorded on electronic care records Mr Turkinas had a history of self-harm. Mr Turkinas denied any current or historical thoughts of self-harm. Notes state he would require opiate withdrawal the following day.

CCTV footage shows Mr Turkinas being placed in a CSU Observation cell[8]. It was determined from this footage that Mr Turkinas blocked the camera in his cell and could not be observed. While being held in the CSU Observation Cell Mr Turkinas used his 'in cell' button on a number of occasions and had short interactions with NIPS staff who attended.

Maghaberry Prison 6 June 2021

On 6 June 2021 at 11:10 Mr Turkinas was transferred from the CSU to Foyle House Landing 1. At this time Foyle House was used for new committals who were beginning their quarantine period as per practice as a result of the ongoing pandemic. Prison Officer A and Prison Officer B searched Mr Turkinas upon arrival and explained the

[8] An observation cell is a cell which has a camera inside for observation purposes.

Foyle House routine to him. Prison Officer A and Prison Officer B both reported Mr Turkinas was smiling and joking and appeared to be in good form.

When Prison Officer A was interviewed, they said of Mr Turkinas:

> "*he shouted (from) the windows something in his own language. I don't know what it was, but it seemed almost that the whole house seemed to erupt with like cheers or shouting or something".*

Mr Turkinas was offered a committal telephone call. Prison Officer A during interview confirmed Mr Turkinas preferred to use the telephone call the following day, Monday, to ring his solicitor regarding his bail. They said:

> *"His solicitor wasn't actually working on the Sunday, and he asked, "Well, then is it okay if I just try in the morning?" And we said, "Yes, that's no problem."*

Mr Turkinas asked the Officers for cigarettes which they provided. He was told that there was no spare lighter for him at the moment but he could ask the Officers for a light when he needed one until a lighter could be provided.

From his arrival until lunch time Mr Turkinas used his cell button three times to request Prison Officers to light cigarettes. Lunch was served at 11:53 and cells were locked at 12:12 in Foyle House.

Between 12:15 and 13:15 Mr Turkinas activated his cell bell a further four times to request lights for his cigarettes. Prison Officers were unable to attend to Mr Turkinas until 13:45 due to providing lunch. During this period, it was noted Mr Turkinas was aggressive when he was unable to have his cigarette lit. Mr Turkinas hit and kicked his cell door; however, he appeared content once he received a light. Throughout the day Mr Turkinas continued to use his cell button for this purpose.

At 14:45 Mr Turkinas was unlocked for a face to face mental health triage. Mental Health Practitioner A met with Mr Turkinas in the recreation room of Foyle House. A

statement of evidence provided by Mental Health Practitioner A stated Mr Turkinas presented as "*bright and reactive*." Mr Turkinas was "*pleasant and jovial throughout and was objectively settled in presentation.*"

Mental Health Practitioner A recorded that there was no evidence on Mr Turkinas' electronic care records that he had any current involvement with community based Mental Health Services. Electronic care records evidenced an urgent referral for suicidal ideation to Community Mental Health Services dated 28 June 2021. This was an error. The referral was made prior to Mr Turkinas entering custody and was made by Mr Turkinas' general practitioner. The correct date should have been 26 May 2021. From records obtained this referral was closed 1 June 2021 as Mr Turkinas did not fully engage with mental health services. As a result, Mr Turkinas was not listed as being engaged in the community with Mental Health Services when committed to Maghaberry Prison.

Mental Health Practitioner A also states, *"information given on committal indicates no current thoughts of* deliberate self harm (*DSH) or suicide"*. Mental Health Practitioner A identified Mr Turkinas' electronic care record did indicate there had been a history of DSH/suicide. Attempts to swallow glass and hanging were referenced.

During the triage it became apparent to Mental Health Practitioner A that the completion of the triage would require the assistance of an interpreter. Access to this service required access to the house clinical room which was locked at that time.

HiP processes, based on *National Institute for Health and Care Excellence (NICE)* guidance, afford the MHT five working days to complete the Mental Health Triage. At this time HiP were piloting a 7 day mental health service. Mental Health Practitioner A stated, given Mr Turkinas' presentation, there were no immediate concerns. Mr Turkinas was advised that a member of the MHT would attend the following day to speak with him and he was agreeable to this. It is recorded Mr Turkinas thanked Mental Health Practitioner A before asking Prison Officer C for a light for his cigarette which he received as he was escorted back to his cell.

At 15:15 Prison Officer C relocked Mr Turkinas. Prison Officer C returned to Mr Turkinas' cell at 15:40 to light a cigarette for him.

At 15:55 Foyle House dinner meal arrived and at 16:00 Prison Officers began the process of distributing meals to prisoners.

5.3 Events after Mr Turkinas was found unresponsive

At 16:04 Prison Officer A opened the flap to Mr Turkinas' cell and saw him suspended from a ligature. The alarm was raised and Prison Officer A unlocked the cell and entered with Prison Officer B, they lifted Mr Turkinas up to support his weight. Prison Officer C entered the cell and cut the ligature while Prison Officer D raised a *"code blue"* alarm.

The Prison Officer accounts record Mr Turkinas was grey, unresponsive and was not breathing. Prison Officer A could not find a pulse and Prison Officer B began CPR while Prison Officer E began mouth to mouth resuscitation. CPR continued on a rotation basis between Prison Officer A, Prison Officer B and Prison Officer D

Nurse E arrived and administered oxygen via an ambubag[9] while Prison Officer E joined the rotation for CPR.

Prison Officer C retrieved the Automated External Defibrillator (AED)[10] and Prison Officer F applied the pads to Mr Turkinas' chest. Two attempts were made with the AED; however, no shock was indicated. On the third attempt a shock was administered.

[9] An ambubag is a self-inflating bag resuscitator that is used to ventilate the individual in need. It consists of a bag made of rubber or silicone, a valve, and a mask. The bag is squeezed by hand to deliver air or oxygen to the persons lungs.
[10] An Automated External Defibrillator or AED is a lightweight, battery-operated, portable device used to help people having sudden cardiac arrest (SCA). The AED checks the heart's rhythm and, if needed, sends a shock to restore a normal rhythm.

Nurse C also attended the scene and took over Mr Turkinas' airway management positioning herself at Mr Turkinas' head. Mr Turkinas required suction due to reflux; Nurse C inserted a new airway post suctioning to optimise his airway.

An ambulance was called at 16:07 and arrived at 16:31 with a second ambulance arriving shortly after. NIAS paramedics arrived at 16:36 and took charge of the resuscitation efforts. NIAS Paramedic A and NIAS Paramedic B called recognition of life extinct at 17:02.

5.4 Hot and Cold Debrief Meetings

Standard 25 of NIPS Suicide and Self Harm Prevention Policy 2011 (updated 2013) states hot and cold debriefs must take place following a serious incident of self -harm or death in custody.

The hot debrief should take place as soon after the incident as possible and involve all the staff who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed and any additional support or learning that could have assisted.

The cold debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify additional learnings.

The hot and cold debriefs took place as expected and were attended by both NIPS and HiP staff.

The hot debrief took place off the Landing Mr Turkinas was housed on but was still in Foyle House. This was not ideal as it was in close proximity to other prisoners who had an awareness that an incident had occurred due to activity on the Landing. Records evidence all in attendance at the hot debrief on 6 June 2021 were praised for their efforts to resuscitate Mr Turkinas and advised of the support services available.

As a result of the location of the hot debrief it was agreed that advice would be sought regarding where best to conduct them in future.

At the cold debrief on 17 June 2021 all parties involved were praised for their efforts. A number of the attendees who were directly involved on the day stated there had been good teamwork and support during and immediately following the incident.

Some NIPS staff felt the available aftercare was not clear or adequate.

5.5 Contact with Mr Turkinas' Next of Kin

Mr Turkinas' next of kin was initially informed of his death by the PSNI. The next of kin contacted Maghaberry Prison directly and spoke with Governor B.

On 22 October 2021 Mr Turkinas' next of kin received a letter from Maghaberry Prison stamped 19 October 2021. This letter appears to have been written during Mr Turkinas' first period in custody the year before. This letter, though ordinary in its content, understandably caused distress to the next of kin.

Although NIPS were not able to provide a reason for this happening they apologised for the incident. The Prisoner Ombudsman's Office have contacted NIPS and confirmed measures are in place to avoid similar occurrences happening in the future.

SECTION 6 - Findings

This section outlines the findings of this report in relation to its objectives.

6.1 The provision of primary and secondary healthcare services provided to Mr Turkinas.

The Clinical Reviewer stated;

> "*the healthcare services provided to Mr Turkinas during his time in custody appeared to have been at least equivalent to what he might have received in a community setting"*.

Mr Turkinas was assessed by multiple healthcare professionals while in custody. Assessments were carried out despite language barriers during both custodial periods.

Mr Turkinas' medical history, particularly concerning substance use and mental health, was partially identified and follow-up plans for further assessments were initiated. There were documented intentions for ongoing evaluations related to his substance use and mental health. These were not completed as a result of Mr Turkinas' death.

The Clinical Reviewer stated;

> *"there is no evidence documented within clinical records from the committal healthcare screening that any form of risk assessment was conducted during this period."*

The Clinical Reviewer stated;

> *"best practice would have been to use established risk assessment tools".*

However, the clinical reviewer also noted that had the mental health triage been;

> "*successfully completed as intended then areas such as precipitating, protective factors and self-harm could have been assessed within South Eastern Health & Social Care Trust triage forms."*

The Clinical reviewer concluded;

> *"community equivalence could not be fully measured or applied due to Mr Turkinas' presentation and aggressive behaviour upon arrival, leading to his placement in the CSU*".

The Clinical Reviewer stated the CSU environment is one which is *"unique to prison settings"* and in turn presented significant challenges in completing a thorough initial assessment and detailed risk evaluation.

At the time of his committal on 5 June 2021, Mr Turkinas was recorded as not currently being on medication, which was consistent with assessments which took place in Maghaberry Prison in October 2020 (Mr Turkinas' previous committal).

The Clinical Reviewer stated;

> *"while there is evidence of previous prescriptions for mirtazapine[11], it is unclear from the available records whether this was an active prescription in the community prior to his committal."*

6.2 Were Mr Turkinas' individual needs met within the prison healthcare environment based on all the information known about Mr Turkinas including his history of drug use and management of withdrawal on his detention.

This report acknowledges that, in accordance with NICE guidelines followed by the Trust, a mental health triage in prison should be completed within seven days.

[11] Mirtazapine is an antidepressant medicine. It's used to treat depression and sometimes obsessive compulsive disorder (OCD) and anxiety.

During Mr Turkinas' first period in custody the clinical reviewer identified records indicating that he was appropriately monitored and assessed for his drug withdrawal, with collaborative management between NIPS and HiP staff under a SPAR Evo care plan.

During his 2021 committal, there were limitations in addressing Mr Turkinas' needs.

The Clinical Reviewer stated;

> *"Mr Turkinas did not fully disclose his mental health history or provide comprehensive details about his substance misuse*".

They found this was likely to have impacted on the ability of HiP staff to address all relevant current clinical information.

The Clinical Reviewer stated;

> Mr Turkinas' "*previous committal records from 2020 should have been available to healthcare staff for his past medical history information."*

While HiP staff referenced information contained in PACE documents, such as Mr Turkinas' substance history and self-harm, beyond planning a withdrawal assessment and a mental health triage for 6 June 2021, no additional needs were identified and /or documented at that time.

The language barrier between HiP and Mr Turkinas appears to have posed a challenge in fully understanding his needs. The absence of a translation service does indicate hinderance to a comprehensive assessment at this early stage.

Additionally, due to Mr Turkinas' behaviour at committal and placement in the CSU further difficulties were present in assessing and managing his individual needs.

All of these factors suggest that while certain aspects of his care were addressed by HiP, there were difficulties and gaps in fully understanding and meeting Mr Turkinas' needs.

The Clinical Reviewer stated these gaps were evident, *"particularly during his 2021 committal."* There was a lack of information recorded to evidence that previous medical records had been reviewed, alongside the absence of translation services preventing healthcare professionals from effectively communicating with Mr Turkinas.

6.3 Sharing of information between the Trust and Prison Service.

Joint working was evident during Mr Turkinas' transfer to CSU, where both NIPS and HiP collaborated to assess his immediate needs following his relocation from a PSNI vehicle.

The Clinical Reviewer concluded;

> *"the information-sharing process between the Trust and Prison Service seems appropriate within the custodial setting"*.

6.4 The adequacy of the initial committal healthcare assessment.

The medical records made by HiP did identify limitations with their assessments, based on language barriers as well as Mr Turkinas' behaviour which were recorded as *"aggressive"* and *"volatile".*

HiP staff asked Mr Turkinas directly for information on his substance use history and his mental health relating to self-harm. From records obtained Mr Turkinas did not disclose his history of self-harm or suicidal ideation. The Clinical Reviewer acknowledged HiP had identified relevant information relating to this which was provided in police documents. These were incidents prior to being committed to Maghaberry Prison on remand.

The Clinical Reviewer stated;

> *"this included an episode of holding a scalpel to his neck and tying clothes around his neck. A past medical history of depression was also noted".*

As Mr Turkinas was transferred to the CSU, there is evidence of a HiP review entered on the HiP computer system; the entry of this review was delayed due to workload. The delay was appropriately referenced by HiP. The review noted areas of bruising to wrists, which were documented appropriately within clinical records on a body chart.

An electronic care record was made to reflect he was on no prescribed medications, as part of Mr Turkinas' initial screening.

Mr Turkinas was known to have a history of substance use, which was identified following committal. The need for withdrawal observations was noted by HiP; however, due to his reported aggressive behaviour, this was to be followed up the next day.

6.5 The adequacy of the healthcare assessments while in the CSU

Mr Turkinas was assessed by HiP following his escorted transfer to CSU by DST. Later that day he was assessed by HiP for initial committal nursing assessment. Both of these assessments were recorded within HiP records.

It should be noted that HiP do not participate in the decision making process as to where individuals are placed within a prison establishment.

The Clinical Reviewer stated;

> "*prisoners are not reviewed by mental health or addiction teams unless they are already on their caseloads during time in CSU*".

During an RQIA review[12] the addictions team raised concerns about inmates, who are not on their caseloads and experience acute withdrawal symptoms in the CSU. This highlighted their belief that this would adversely affect their physical and mental wellbeing. Mr Turkinas, who struggled with both mental health and substance-related issues, was placed in the CSU immediately upon arrival and was not on any caseload, meaning he would not have been seen by specialist services. Furthermore, due to the language barrier with Mr Turkinas, being able to accurately complete an assessment, record risk and identify management without the use of an interpreter would have been problematic for healthcare staff.

The Clinical Reviewer stated;

> "*the need for accessible and timely access to translation services, within the CSU is indicated as an area for learning. This is to ensure that individual needs, risk and health can be quickly and appropriately managed.*"

The Prisoner Ombudsman was minded to make a recommendation in regards to translation services however, upon further review it was evident significant improvements to the availability and access to these services had already been made in the subsequent time since Mr Turkinas' death.

NIPS confirmed electronic tablets are now in use in various parts on the establishment. They also confirmed plans are in place to increase the number of electronic tablets available. The Trust advised HiP has access to "The Big Word" and face to face interpreter services through the Trust on a scheduled basis.

[12] The Regulation and Quality Improvement Authority. (2021). *Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons*. https://www.rqia.org.uk/RQIA/files/95/955cfa4a-5199-4be7-9f1a-801e1369ce84.pdf

6.6 The impact, if any, of the decision made by the MHT on Saturday to delay their triage in order to arrange for a translator.

A mental health triage was attempted within the recreational room on 6 June 2021. It is documented within medical records that Mr Turkinas attended for the triage of his own "volition". Due to language barriers the triage and mental health triage could not take place in full.

The Clinical Reviewer stated;

> *"Without the use of any translation services since Mr Turkinas arrival, it is not possible to determine the level of impact this delay may have caused…..Whilst the decision to delay the Mental Health assessment* (triage) *was reasonable whilst awaiting translation services, the need to wait to access translation services to conduct health related assessment, is unsuitable."*

It was evident when mental health staff attempted to conduct this assessment Mr Turkinas was willing to engage and was no longer presenting with aggressive behaviour.

The Clinical Reviewer stated;

> *"the delay in this assessment was entirely due to language issues."*

Therefore, a recommendation for timely access for translation services by healthcare staff has been included as part of this clinical review.

6.7 The appropriateness of the decision to commence cardiopulmonary resuscitation (CPR). Was the resuscitation conducted in line with national guidelines?

The Clinical Reviewer stated;

> "*the decision to commence CPR for Mr Turkinas and the subsequent resuscitation efforts appear to have been both appropriate and in line with national guidelines".*

The Clinical Reviewer provided the following rationale;

> *"Approximately 25 minutes prior to the call for the emergency alarm, Mr Turkinas had been seen by NIPS staff who provided a light for his cigarette. This indicates a short window in which Mr Turkinas proceeded to take his life, by means of a ligature. Due to this, commencement of CPR by NIPS staff appears appropriate and in line with best practice and policy. He was found in his cell, with officers reporting in their statement "He was floppy…completely unresponsive. He was a really bad colour, he was a grey colour[13]"."*

The Clinical Reviewer confirmed in "*this case the absence of irreversible signs indicated that resuscitation efforts may have had the potential to be successful".* This justified the initiation of CPR by officers, alongside the continued efforts when healthcare staff arrived.

6.8 The impact, if any, on the length of time Mr Turkinas was in prison before he had an opportunity to engage with agencies and mental health programmes to help with his addiction and overall mental health and wellbeing.

Mr Turkinas' period in prison may have been impacted by his denial of any mental health conditions, history of self-harm or suicide attempts following committal; however, he had reported opiate use after his first committal in 2020.

The Clinical Reviewer stated;

[13] Transcript Prison Officer C interview, 16 November 2021

"while an opiate withdrawal scoring was started during committal in 2020, there is no evidence from records available he engaged in any other substance use related assessments or programs".

In October 2020, during Mr Turkinas' first custodial period, Mental Health Services conducted an immediate assessment, noting there was no requirement for him to be added to the caseload, suggesting referral could be made "*in the future if clinically indicated*."

In October 2020, Mr Turkinas was on a SPAR Evo care plan. This SPAR Evo was closed on the same day as his mental health assessment. The Clinical Review stated the evening following the mental health assessment and SPAR Evo closing, Mr Turkinas set fire to his cell for which Mr Turkinas was put on a SPAR Evo care plan; however the Clinical Review stated records did not indicate Mr Turkinas was asked about his reasoning behind this and if it was in an attempt to commit suicide. Records evidenced Mr Turkinas was seen by HiP as part of the Spar Evo closing, 2 days after the fire, when Mr Turkinas was recorded as not having current thoughts of self harm or suicide.

During his second committal Mr Turkinas arrived on a Saturday afternoon (5 June 2021) and was taken directly to CSU. On Sunday 6 June 2021 he was moved to Foyle House where, within a matter of hours, he was found unresponsive in his cell.

In relation to the short period in custody in 2021 the Clinical Reviewer found it was not possible to determine if this had any direct impact either to Mr Turkinas' health, wellbeing or in any way influenced his actions in taking his own life.

HiP completed the required post control and restraint assessment following transfer to CSU. A Mental Health triage was attempted but could not be completed due to a language barrier. This was to be completed on Monday 7 June 2021 within MHT timescales.

A referral for a mental health triage was identified. From electronic care records obtained a substance withdrawal referral was also planned for Sunday 6 June 2021.

6.9 To what extent did the Covid-19 pandemic impact on Mr Turkinas' primary and mental health care during both periods of custody? What impact, if any, could 14 days of isolation have had on someone with Mr Turkinas' mental health history?

The pandemic significantly affected service and care delivery globally including Prison Service and Healthcare delivery. The Clinical Reviewer found it was not possible to comprehensively measure the impact of the pandemic on Mr Turkinas.

The impact of the pandemic on Mr Turkinas' primary care and mental health care while in Maghaberry Prison appears to have been minimal. Mr Turkinas had been in custody of Maghaberry Prison in 2020 and he was aware of the need for quarantining on arrival on his second committal. Mr Turkinas was moved from CSU to committal quarantine in Foyle House on 6 June 2021.

Assessments carried out as described in previous sections, did not indicate Mr Turkinas was prevented from accessing services based on restrictions imposed due to the pandemic.

The Clinical Reviewer did comment on quarantining. They said;

> *"Isolation in prison, particularly during reverse cohorting* (committal quarantine)*[14], is known to worsen mental health, especially for individuals with a history of mental health disorders. Research shows that extended isolation can lead to increased symptoms of depression, anxiety, and feelings of*

[14] Committal Quarantine is the temporary separation of newly committed persons to prison from the mainstream population in order to reduce the risk of communicable disease to the general population and transmission risk to all the people present in an establishment.

hopelessness[15]. Whilst Mr Turkinas medical history included suffering with depression, he was not actively involved in any treatment either via therapy or pharmaceutical routes at the time of his committal. Studies have shown that individuals with pre-existing mental health conditions are at greater risk of experiencing exacerbated symptoms when subjected to prolonged isolation"

At the time HiP had a Service Level Agreement of 5-days from committal to complete their assessment there would have been opportunities for HiP and NIPS to monitor Mr Turkinas' health and wellbeing.

6.10 The adequacy of the support services provided to staff involved in this incident.

The Clinical Reviewer states the support provided to staff involved in this incident "*appears to have been adequate*". A hot debrief was held on the day of Mr Turkinas' death and a cold debrief was held on 17 June 2021. This allowed HiP and NIPS staff to share their thoughts and experiences regarding the incident.

The Clinical Reviewer concluded;

"overall, there was evidence that staff involved in the incident had multiple avenues of support available to them, if they chose to access it".

6.11 Areas for Improvement or Commendable Practices.

HiP staff deemed it was not possible to complete withdrawal observations in the immediate period following Mr Turkinas' transfer to CSU. The Clinical Reviewer stated this was reasonable given the documented issues with his behaviour.

[15] The Department for Digital, Culture, Media and Sport (2022). *Mental health and loneliness: the relationship across life stages.* https://www.gov.uk/government/publications/mental-health-and-loneliness-the-relationship-across-life-stages/mental-health-and-loneliness-the-relationship-across-life-stages

The audit trail within medical records shows withdrawal observations were planned by the nurse to be completed between 08:00 and 17:00 on 6 June 2021. There was no evidence withdrawal observations were completed between Mr Turkinas' arrival in CSU, on 5 June 2021 and the emergency alarm response approximately at 16.07 on 6 June 2021. There was also no evidence of a comprehensive assessment being conducted within this timeframe to establish Mr Turkinas' needs relating to his substance use.

This report acknowledges that, in accordance with NICE guidelines followed by the Trust, this assessment in prison should be completed within seven days.

Access to translation services should be available to NIPS and HiP staff in a timely manner to ensure healthcare and risk assessments can be conducted for individuals who lack fluency in English. The Clinical Reviewer stated;

> *"This is imperative to ensure both comprehensive assessments can be conducted and there is an informed approach to potential risks to individuals. This is especially important for those with increased vulnerabilities such as mental health and substance misuse history"*

SECTION 7 – Conclusions

1.	**To establish the circumstances and events surrounding Mr Turkinas' death on 6 June 2021 including an overview and examination of his committal and the immediate responses when he was found.**
	The circumstances of Mr Turkinas' death are outlined in Section 5. Consideration of appropriateness in the level of care provided by NIPS and HiP in the hours immediately leading up to Mr Turkinas being discovered in his cell can be found in Section 6.
2.	**To examine whether the provision of healthcare services provided by the Trust to Mr Turkinas were at least equivalent to those he might have received in the community.**
	Based on the evidence provided I am satisfied the care provided by NIPS and the HiP to Mr Turkinas was appropriate.
3.	**To identify any relevant failing or commendable practice, and highlight any lessons learned from the death of Mr Turkinas.**
	Areas of good practice and learning are included in Section 6.11 and 8.
4.	**To assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights by ensuring as far as possible the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified and any lessons from the death are learned.**

This report will be provided to the Coroner along with full disclosure of investigative materials to inform the inquest.

SECTION 8: Good Practices

Pandemic restrictions significantly impacted daily activities. Procedures to manage prisoner interaction, mitigating measures including meaningful contact opportunities were in place.

The emergency response to Mr Turkinas was prompt and adhered to best practices.

Mr Turkinas received healthcare at least equivalent to that available within the community.

The decision to commence CPR and the resuscitation were conducted in accordance with best practices and national guidelines.

This report recognises the collaborative efforts of NIPS and HiP in ensuring prisoner welfare despite the pandemic constraints. It also emphasises the necessity of enhancing conditions for prisoners particularly those with mental health and addiction vulnerabilities during periods in quarantine.

Section 9: Learnings and Recommendations

My recommendations are detailed below:

Recommendation 1.

The NIPS First Night Questionnaire should be completed by all committals on all occasions. If a prisoner is taken to another house other than the committal house, the questionnaire should be completed as a matter of urgency at that location.

All known pertinent information relating to prisoners mental health and history of self harm/suicide should be prioritised and highlighted to all relevant staff, particularly those closest in terms of managing that prisoners care, in advance of a prisoner entering the House/Landing.

Mr Turkinas re-entered custody with complex health needs and dependencies which should have been quickly identified. Attempts to identify these however were hindered by his behaviour, language difficulties, gaps in processes and inadequate access to services.

NIPS staff who worked in Foyle House on the date of Mr Turkinas' transfer from CSU stated they were unaware of any additional care needs or history of self-harm in regard to Mr Turkinas. NIPS staff confirmed Mr Turkinas was transferred to Foyle House but no *"file"* accompanied him from CSU. When queried by the interviewer NIPS staff confirmed a file, which normally contained PACE notes and similar documents, was not present with Mr Turkinas. NIPS staff confirmed this file may have highlighted some of the additional needs or self-harm occasions in Mr Turkinas' recent past.

NIPS confirmed the process to be followed is as below:

> *All information provided on the PECCS and PSNI notes is transferred onto the first night questionnaire on the committal checklist within PRISM. This is done as soon as they are committed to Prison. A hard copy is given to the nurse in*

Foyle House. A hard copy is put in their file which goes to Bann House after they come out of isolation and the original copy is kept in their custody file.

Mr Turkinas did not complete a first night questionnaire and nothing of note was uploaded to the Prison Service computer system. Staff in Foyle House had nothing to review in regards to Mr Turkinas. The *"file*" was not viewed by any of the staff in Foyle House.

Recommendation 2.

NIPS must reassess and identify an area, or areas, within the establishment as the location of hot and cold debriefs for future instances to guarantee the suitability of the location is adequate.

The hot debrief took place in a timely manner. Some of the NIPS staff present commented on the location and proximity to other prisoners.
Prison Officer C, when interviewed stated the hot debrief was *"awful"*. They said;

"Well, all other prisoners were going buck daft. They were screaming and shouting and kicking their doors…..It was horrific. I don't know why they went up there, but they did. They were banging. It was just boom, boom, boom and screaming and shouting. It was awful. Really bad. Like you could hardly hear because they were banging so loud."

The hot debrief took place off the Landing Mr Turkinas was on but was still in Foyle House in close proximity to other prisoners on another landing. Prison Officer F was asked during interview if this was normal behaviour from the prisoners and stated;

"No I don't know why that, it must have been they knew, cause they saw so many police and cars and Governors in and stuff like that, yeah I think it was just acting the maggot basically you know, because there was a lot of commotion going on outside, as in you know there's all the, you know being

able to see that there were police vehicles there, ambulances and maybe governors in or whatever I don't know, but they were just, basically mental like."

More consideration should be given when deciding on a location for debriefs. These should be in more private settings and away from distractions by third party actions.

APPENDIX 1

GLOSSARY

AED	Automated External Defibrillator
CCTV	Closed-Circuit Television
CPR	Cardiopulmonary Resuscitation
CSU	Care and Supervision Unit
DST	Dedicated Search Team
ECHR	European Convention on Human Rights
HiP	Healthcare in Prison
MHT	Mental Health Team
NHS	National Health Service
NIAS	Northern Ireland Ambulance Service
NIPS	Northern Ireland Prison Service
PACE	Police and Criminal Evidence Act 1984
PSNI	Police Service Northern Ireland
SEHSCT/ the Trust	South Eastern Health and Social Care Trust

Appendix 2

Criminal Justice Inspection Northern Ireland (CJI)

CJI is a United Kingdom National Preventive Mechanism (NPM) member body that independently monitors places of detention to prevent the ill treatment of prisoners. CJI inspects Northern Ireland prisons in partnership with His Majesty's Inspectorate of Prisons (HMIP), the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate. HMIP and the RQIA are also NPM members.

In 2019 the CJI and the RQIA published a joint report on the Safety or Prisoners which is available at CJINI - Criminal Justice Inspection Northern Ireland - The Safety of Prisoners .

At the time of Mr Turkinas' death the most recent inspection of Maghaberry Prison by the CJI had taken place in April 2018 and the report published in November 2018. The report is available at CJINI - Criminal Justice Inspection Northern Ireland - Maghaberry Prison.

CJI reports are available at Maghaberry Prison inspection report June 2023, CJINI Independent Review Progress Report 2024 and CJINI Full Inspection May 2015

Regulation and Quality Improvement Authority (RQIA) Review of Services for Vulnerable Persons detained in Northern Ireland Prisons

Following a report of an accident of serious self-harm from the Prisoner Ombudsman's Office in 2016 and the number of recorded suicides in prisons, the Departments of Health and Justice jointly commissioned a review to consider provision for particularly vulnerable prisoners. The RQIA Review, published in October 2021, goes some way to addressing concerns. Recommendations made by the RQIA specifically address

mental healthcare. The Ombudsman works with the RQIA and others to raise matters of concern and improve the delivery of support to prisoners.

The RQIA report is available here.

Independent Monitoring Board (IMB)

Maghaberry Prison has an IMB of volunteers whose role is to independently monitor the care and treatment of prisoners.

From the 2021-2022 Maghaberry Prison IMB annual report the IMB state there has been clear evidence of prison staff intervention in relation to prisoners who may attempt suicide or inflict self-harm which has improved the safety and wellbeing of prisoners.

The IMB would acknowledge the excellent work carried out by staff in this regard to ensure the safety of prisoners, especially those who have been identified as being vulnerable.

The IMB did however, continue to have some concerns regarding the standard of accommodation within Foyle during this year particularly around lack of furniture and non-working showers, and the impacts on prisoners due to Covid-19 restrictions particularly 23 hour lock ups.

IMB Annual Reports can be viewed at Independent Monitoring Board (imb-ni.org.uk)

Appendix 3

Guidance during the Covid-19 pandemic

NIPS worked with SEHSCT Infection control specialists from February 2020 in preparation for the pandemic and was informed by PHA and the HSCB from April 2020. NIPS and SEHSCT colleagues were also representatives on the 5 Nations Covid-19 Health and Justice group that proved a valuable forum in learning from other jurisdictions.

NIPS recognised that the general prisoner population did not present a risk; it was people coming into prison (staff and new committals) that posed a risk of transmission of the Covid-19 virus to general population. NIPS restricted staff access early on to essential staff (NIPS and SEHSCT) and introduced committal quarantine to protect the general prisoner population.

Committal quarantine was implemented for 14 days, based on PHA advice and quarantined prisoners were held in specific accommodation, with largely the same staff group in place. Committal quarantine was reduced to 10 days from 12 November 2021, subject to the individual agreeing to be tested for the virus (again, informed by PHA advice).

NIPS implemented its formal Pandemic Plan and procedures in June 2020 that included infection control measures, quarantine and isolation arrangements (for staff and prisoners) and virtual visits etc. The SET/NIPS Quarantine Arrangements for new committals during Covid-19 Pandemic was included at Appendix C and was informed by advice from Public Health England and our own Public Health Agency. The document was revised regularly in line with Chief Medical Officer and PHA advice, version 7.0 contained changes effective from 31/12/21 and 10/01/22, and version 8.0 was implemented 31/01/2022.

Prisoners held in Foyle House quarantine landings had a TV in their cell, distraction packs and access to in-cell exercise equipment (procedure through funding provided by HSCN). All prisoners were facilitated to have regular showers and phone calls and,

apart from check-ins with NIPS staff, quarantined prisoners were seen by Healthcare in Prison staff daily. In addition, the HiP Prisoner Engagement staff also visited with each prisoner.

Measures to contain the spread of the COVID-19 pandemic

The Ombudsman acknowledges the Covid management procedures, NIPS introduced at the time of Mr Turkinas death at Appendix 3

The global impact of the pandemic included the protection of particularly vulnerable groups of people including those in prisons. As noted by the World Health Organisation[16]:

People deprived of their liberty, such as people in prisons and other places of detention, are more vulnerable to the coronavirus disease (COVID-19) outbreak. People in prison live in settings in close proximity and thus may act as a source of infection, amplification and spread of infectious diseases within and beyond prisons.

For prisons, standards remained critical at a time when they also had to fulfil the positive duty to protect life. These standards are set out in the *United Nations Standard Minimum Rules for the Treatment of Prisoners*, also known as the *Nelson Mandela Rules*, and are foundational to preventing the ill-treatment of those in custody. The Ombudsman's Office received a number of complaints relating to measures in place during the pandemic and its impact continues to feature in current investigations. Pressure on healthcare services is a theme across the United Kingdom and the prison population is no different. The ongoing impacts of the pandemic are important particularly in the area of mental health.

From the beginning of the pandemic NIPS was aware of the enormity of the task facing them. They had a responsibility, a positive Article 2 of the ECHR duty, to keep those residing and working in prisons safe. At the same time, they had to balance prevention and containment with maintaining standards for the care and rehabilitation of prisoners.

[16] https://www.who.int/europe/activities/ensuring-prevention-and-control-of-covid-19-in-prisons-and-other-places-of-detention

The Minister of Justice and NIPS followed a similar incremental pathway as Great Britain with regard to prisons: suspending visits on 20 March 2020, gradually closing the prison estate to all but essential workers, limiting movement within prisons and ensuring safety measures were in place within each prison.

In March 2020 Governors received instructions to focus on infection control and minimise the risk of transmission. Between 20 and 25 March 2020 they took significant action to minimise risk, including the:

- suspension of all domestic and legal in-person visits to prisons;
- suspension of accompanied and unaccompanied temporary release, including all release under the home leave scheme;
- access to prisons was restricted for all but essential prison staff and healthcare workers; and
- quarantine for 14 days for those coming into custody.

Testing, contact tracing and infection control measures kept pace with wider society. From March 2020 all new committals were placed in quarantine for 14 days on arrival, in line with PHA advice. From April 2020 NIPS met weekly with the Trust, the PHA and the Health and Social Care Board to oversee what was happening in prisons and share knowledge and learning. In the early stages of the pandemic everyone was learning and developing an understanding of how COVID-19 affected health.

The NIPS assessment and management of the risks posed by the virus focused on:

- promoting the health and safety of those in custody, prison staff and the wider public;
- preventing the introduction of Covid-19 into prison;
- preventing the transmission of Covid-19 within prison; and
- preventing the spread of Covid-19 from prison to the community.

Consideration of special precautions to prevent introduction of virus in community transmission scenarios.

> *Prison outbreaks are most likely to occur as a result of introduction of the virus from external sources, especially if there is widespread community transmission. It is therefore advised that a 14-day period of quarantine is used for all people coming into prison (new arrivals and transfers from other institutions) before they are allowed to join the general prison population (59). The same quarantining principles that are used for case contacts should be followed.*
>
> World Health Organisation (WHO) guidelines

In keeping with WHO guidance, Maghaberry Prison activated plans already in place by introducing Foyle House Covid Quarantine Unit, where all new committals to Maghaberry Prison were isolated for 14 days.